1

What Are Psychoactive Drugs, Who Uses Them and Why?

What Are Psychoactive Drugs?

A psychoactive drug is a chemical substance that alters the functioning of the brain, causing changes in the way we think, feel and behave. All drugs can be divided into those that have psychoactive effects and those that don't. Most drugs, for example medications like antibiotics, are not psychoactive. Antibiotics treat infections, but they don't change our emotions. Psychoactive drugs can be stimulating, sedating, cause hallucinations or produce an out-of-body state called dissociation. Some psychoactive drugs can cause more than one of these effects.

How Much of a Problem Are Psychoactive Drugs?

Before we talk more about psychoactive drugs and the problems they can cause, let's look at how commonly they are used. The United Nations Office on Drugs and Crime (2022) estimates that around 1 in 18 people of the world's population between 15 and 64 years of age have used an illicit psychoactive drug in the past year. That's around 275 million people. Of these people, more than 1 in 10 experience problems with their drug use, and globally almost half a million people a year die from drug-related causes.

The UK government conducts an annual survey estimating drug use in England and Wales (Office for National Statistics, 2023). It shows that around 1 in 10 people aged between 16 and 59 years used illegal drugs in the past year – approximately 3.1 million people. By far the most used drug is cannabis. As with all surveys, some people will not

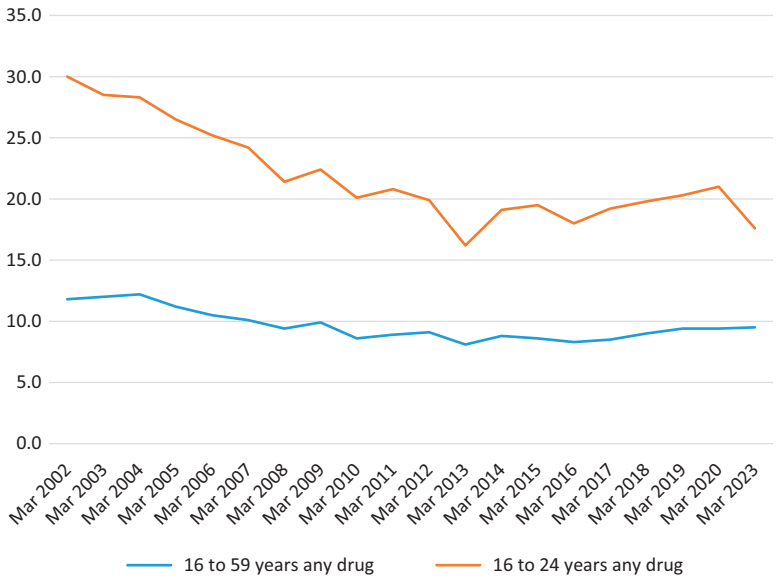

Figure 1.1 Proportion of people reporting use of any drug in the last year in England and Wales (Office of National Statistics, 2023).

tell the truth, inflating or reducing the estimates, but a yearly survey does give an indication of changes in patterns of drug use over time. The survey results suggest that over the last 20 years there has been a gradual reduction in the number of people using drugs, although there are differences between age groups which we will explore later (Figure 1.1).

The trends also vary depending on which individual drug you look at. While heroin use seems to be declining in the general population and in young people in particular, other drugs appear to change popularity, coming in and out of fashion. Most newer drugs are not accurately recorded in surveys, so their use is likely to be underestimated. Chapter 6 discusses them in more detail.

Young People and Drug Use

Psychoactive drug use is more common in younger people. Many young people who use psychoactive drugs will do so briefly (perhaps out of curiosity), decide it is not for them and stop. A small proportion of young people, however, will begin to use more regularly. In general, the more often a psychoactive drug is used, the greater the likelihood that it will cause problems.

So, what does the UK drug survey tell us about young people? Looking at those between 16 and 24 years of age, around one in five young people used an illegal drug in the past year, equivalent to around one million people. Some people may think that one in five young people is a lot, while others may have expected the figure to be higher. One thing is clear from the survey: Most young people do not use drugs. This is an important message, as drug use is often considered a normal behaviour by some young people, and this view can be perpetuated by the media. What's more, the number of young people who report taking drugs has been declining over the last 20 years before stabilizing around 2018 (Office for National Statistics, 2023). As we will see in later chapters, the patterns for individual drugs have been quite different, with some falling out of fashion while others have

gained popularity. The last survey was conducted in 2023 and showed a further unexpected reduction in drug use in young people. There is not yet a clear explanation for this recent drop, but the COVID-19 pandemic and subsequent lockdowns have affected drug use in complex ways which researchers are still investigating.

When Do Young People Start Using Drugs?

The UK government also measures drug use in school-aged children. Around a fifth of 15-year-olds report having taken a drug at some point in their lives, and one in eight reported use in the past year (NHS Digital, 2022). In the same survey, half of 15-year-olds said that they had been offered illegal drugs, a figure that I suspect will alarm many parents.

Another estimate of drug use in young people comes from the United States. The Monitoring the Future project (www.monitoringthefuture.org) has recorded drug use in US school-aged children since 1975. Approximately 50, 000 pupils take part in the annual survey, and, like the annual survey of England and Wales, it can track trends over time. The US survey suggests even higher levels of drug use than in the United Kingdom. Around a third of US 15-year-olds report ever using an illegal drug, with one in five using in the last year. Interestingly, like in the United Kingdom, since the COVID-19 pandemic these figures have dropped considerably.

Both the UK and US figures suggest that a significant number of young people have experimented with drugs by their mid-teens. This is important when we think about the best time to start talking to our children about psychoactive drugs.

Which Drugs Are Young People Using?

The popularity of different drugs changes over time and with the age of the person using the drug. Figure 1.2 shows the patterns of drug use by UK schoolchildren. The use of volatile substances, such as aerosols or glue, is most common in younger people before rapidly declining.

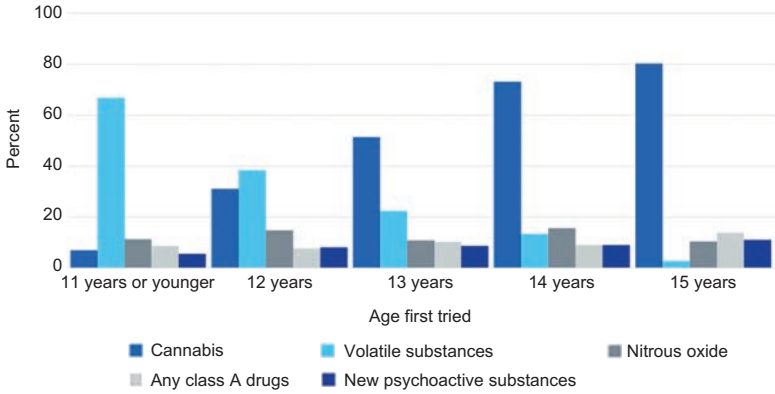

Figure 1.2 Drugs taken at age of first drug use, by age first took drugs (Smoking, drinking and drug use among young people, 2021).

Cannabis use, however, takes off around 12 years old and steadily increases with age.

From 16 years of age onwards, cannabis remains the most common drug across all age groups but peaks in the late teens. Ecstasy (3,4-methylenedioxymethamphetamine, or MDMA) use peaks in the early 20s, and powder cocaine use is most common in the late 20s.

Drug preference is influenced by many factors, including availability, cost, desirability and perceived acceptability. Some drugs are associated with particular social or ethnic groups. For example, the electronic dance music scene is associated with the stimulant drug ecstasy (Winstock et al., 2001).

Household Income and Where You Live

Sometimes you hear people say that drugs are only used by people living in disadvantaged circumstances with a lack of opportunity and resources, and that people with plenty of money are insulated from the risk of using drugs because they have the means to enjoy other activities. The reality is much more complicated. Take, for example, the common perception that illegal drugs are only available in big cities.

While it used to be the case that illegal drugs were more available in cities compared to more rural areas, this has begun to change. The availability of illegal drugs to purchase online or using social media is one reason. Another is the changing business model of organized criminal groups who now send drugs to smaller cities and rural areas using often vulnerable young adults in a system known as 'county lines'. We will discuss this later, but the message is clear: It does not matter where you live or who you are in society, the use of drugs is something that affects everyone.

What Do Young People Think about Drugs?

Most adolescents disapprove of using psychoactive drugs. Asked the question 'Is it OK to try taking cannabis to see what it is like?', fewer than 1 in 20 UK children under 13 years of age agreed. But by 15 years of age, one in four answered yes. At this age, trying cannabis was still less acceptable than trying tobacco (almost half of all 15-year-olds agree) or alcohol (three-quarters of 15-year-olds agree) (NHS Digital, 2022).

The Monitoring the Future project also asks school-aged US children about attitudes. Rather than asking if drug use is acceptable, they ask if the children disapprove of different drugs. By 15–16 years of age, only half of the US children surveyed disapproved of cannabis. It is as yet unclear what the impact of cannabis legalization in some US states has had on the attitudes of young people in the United States, and indeed the United Kingdom. US children's disapproval of other drugs remained high (Johnston et al., 2022).

Although we can't directly compare the UK and US results – because they ask different questions – the overall findings are strikingly similar. Most children in their early to mid-teens disapprove of drugs, but drugs become more acceptable as they get older. Why do their attitudes change? In general, attitudes change because of new information and the opinions of those around you. As adolescents

mature and explore their expanding worlds, what they are told about drugs, and by whom, is likely to be very influential. Having the right information is important at any age, but for adolescents having the right information is essential.

KEY MESSAGES

- Drug use is common. It is estimated that 1 in 10 people in the United Kingdom have tried an illegal psychoactive drug in the last year.
- Young people use more drugs than any other age group, many by their mid-teens.
- Cannabis is the most commonly used illegal psychoactive drug.

What about the Law?

Many psychoactive drugs, such as heroin or cocaine, are illegal because of their harmful effects. The legal status of a particular drug differs from country to country, but in general, drugs that cause more harm have stricter controls. In the United Kingdom, there are two laws governing illegal drugs: the Misuse of Drug Act (1971) and the Psychoactive Substance Act (2016). Under the Misuse of Drugs Act, illegal drugs are divided into three broad categories depending on their estimated level of harm: Class A (the most harmful), Class B and Class C. These classes carry different penalties for producing, selling or possessing drugs in that class (Table 1.1).

This classification system works best when the harms of a particular drug are well understood and a decision about the most suitable classification can be made on good evidence. Sometimes a drug will change classification if new harms emerge, as happened with gammahydroxybutyrate (GHB) when it was moved from Class C to Class B after it became clear that it was being used as a date rape drug and to deliberately poison people (Bowden-Jones, Priti and Mp, 2020).

Table 1.1 UK drug classes and maximum penalties for possession and supply/production

Class	Drug	Maximum penalty for possession	Maximum penalty for supply and production
A	Crack cocaine, powder cocaine, ecstasy, heroin, hallucinogens (lysergic acid diethylamide (LSD), magic mushrooms, 2CB) methadone, methamphetamine (crystal meth)	Up to 7 years in prison, an unlimited fine or both	Up to life in prison, an unlimited fine or both
B	Amphetamines, barbiturates, cannabis, codeine, ketamine, methylphenidate (Ritalin®), synthetic cannabinoids, synthetic cathinones (e.g., mephedrone, methoxetamine), gammahydroxy-butyrate (GHB), gammabutyrolactone (GBL)	Up to 5 years in prison, an unlimited fine or both	Up to life in prison, an unlimited fine or both
C	Anabolic steroids, benzodiazepines (diazepam), piperazines (BZP), khat, nitrous oxide (since 2023)	Up to 2 years in prison, an unlimited fine or both (except anabolic steroids – it's not an offence to possess them for personal use)	Up to 14 years in prison, an unlimited fine or both

Table 1.1 (cont.)

Class	Drug	Maximum penalty for possession	Maximum penalty for supply and production
Temporary class[a]		None, but police can take away a suspected temporary class drug	Up to 14 years in prison, an unlimited fine or both

[a] The government can ban new drugs for 1 year under a temporary banning order while they decide how the drugs should be classified. Source: www.gov.uk/penalties-drug-possession-dealing.

What happens when a new drug first appears about which very little is known? How can the government decide if a new drug should be Class A, B or C if the level of harm it causes is unclear? Around 2010, the United Kingdom and many other countries saw the beginning of a wave of new drugs appear on illegal drug markets. Hundreds of new drugs began to be detected, many with completely new chemical structures, and it was unclear what harms they could potentially cause. This lack of understanding made it hard to work out the most appropriate classification. In response to the challenge of so many new, poorly understood drugs, the UK government developed a new drug law, the Psychoactive Substance Act 2016. This new Act made it an offence to produce, supply, import or export any psychoactive substances (with a psychoactive substance being defined as anything which, by stimulating or depressing the person's nervous system, affects the person's mental functioning or emotional state). This is a very different approach to the Misuse of Drugs Act 1971, as it does not rely on proof that a drug is harmful, instead focusing on whether a drug can cause any sort of psychoactive effect. The new law made exemptions for a range of existing psychoactive drugs including alcohol, nicotine, caffeine, medicinal products and any drugs already regulated under the Misuse of Drugs Act.

The two drug laws are designed to work together. When a new substance appears on drug markets, if it has a psychoactive affect, it automatically falls under the Psychoactive Substances Act 2016, making it an offence to produce, supply, import or export the drugs. The maximum sentence is 7 years in prison. Interestingly there is no possession offence, meaning that it is not an offence to carry the substance on your person. The lack of a possession offence was probably an acknowledgement that the harms of the drug are unknown. The law is essentially trying to stop new, unknown drugs from being sold rather than to target people using the new drugs. If clear evidence emerges that a particular drug is harmful, then the drug moves across to the Misuse of Drug Act 1971, which then classifies the drug according to the level of harm and places greater sanctions on production and supply as well as introducing a possession offence (see Table 1.1).

What about Legal Psychoactive Drugs?

So far, I have talked only about psychoactive substances which are illegal. There are, of course, a range of legal drugs, such as alcohol, nicotine, caffeine and many medicines, which can cause psychoactive effects and subsequent harm such as dependence, withdrawal and overdose. Many parents will feel more knowledgeable and confident talking to their children about the potential risks of drinking alcohol or smoking cigarettes, but a word of warning. The use of legal psychoactive substances is also changing rapidly. Vaping using electronic cigarettes has changed how many young people consume nicotine, while youth drinking habits are also rapidly evolving. For this reason, I have devoted Chapter 8 to discussing what you need to know about legal psychoactive drugs.

Why Do People Use Drugs?

Having looked at how common drug use is, it is now time to think about why people use psychoactive drugs in the first place. The simple answer is that people take drugs to change the way they feel, even if only for a

short time. Psychoactive drugs are a powerful and reliable way to change a person's psychological state. Drugs can be stimulating (making the user feel energised), sedating (leading to feelings of relaxation and calm), hallucinogenic (causing a person to see images or hear sounds that are not really there) or dissociative (resulting in 'out-of-body' or 'near-death' experiences). Most drugs work quickly, are relatively cheap and widely available. Some of my patients tell me that if they wanted to, they could buy drugs within 20 minutes of leaving my office. So, if you want to use a psychoactive drug, it's easy to find and affordable.

If we accept that using a psychoactive drug is a reliable, if potentially high-risk, way to change the way you feel, then the question becomes why people want to feel different in the first place. Psychoactive drugs affect the brain by either giving a person new feelings or taking away existing feelings. In essence, people take drugs to feel good or to stop feeling bad. Here are two very different scenarios.

John's Story

John is 16 years old. He is going out clubbing with friends from school to celebrate the end of his summer exams. John has been looking forward to it all week and knows that the party will begin on Friday evening and continue all night. He is going to a new club and is really excited about the DJ and the venue. John and his friends plan to take drugs, in this case the stimulant drug ecstasy. A few days ago, they bought enough pills for all of them from a friend of a friend.

On Friday, John tells his parents that he is going to visit a friend and stay with them overnight. Instead, he meets his other friends at a bar, and they have a few drinks before heading to the club. John is feeling in the mood to celebrate but also feels physically tired from late nights spent studying. They reach the club around 11 pm and use fake IDs to gain entry. Once inside, they all take their first dose of ecstasy.

Within about half an hour, the drug takes effect. John is now excited, full of energy and very sociable. He's aware that he is talking too much and can't keep still. He can't stop himself from grinning – a well-known side effect of ecstasy. The music and lasers become more intense as the ecstasy takes effect. As he dances, John experiences an overpowering euphoria.

Around 2 am, John begins to flag as his energy levels drop. It is time for another dose. John is an experienced ecstasy user and has judged from the effects of the first pill that this ecstasy is probably stronger than usual. He also knows that the more he takes, the greater the 'crash' will be over the next few days, so he decides to take half a tablet and 'play it safe'.

The second dose works quickly, and soon John is back dancing with his friends and really enjoying himself. Towards the end of the night, about 5.30 am, the second dose begins to wear off. John doesn't want to use any more ecstasy, as he has plans to meet a friend on Sunday and doesn't want to spend his weekend recovering from the drug's effects. Instead, he moves to the club's chill-out room to cool down. His friends agree that the night has been a spectacular success and that the DJs were brilliant.

John and his friends leave the club about 7 am on Saturday morning feeling physically tired but still mentally very alert from the ecstasy. They know they won't be able to sleep yet, so they all go and have breakfast before heading home. John arrives at his friend's house around 10 am, still feeling 'wired'. He smokes half a joint of cannabis to calm himself and eventually falls asleep around 11 am.

Over the next few days, John feels flat and exhausted. His concentration is poor, and he is more irritable than usual. He is well aware that these are the effects of his ecstasy use, as he has experienced them many times before. The feelings peak on Monday afternoon when, for a few hours, John feels sad and upset, but he knows these feelings will pass and believes it is a price worth paying for his night out with friends.

By Thursday, he is feeling back to normal. John makes a mental note to not use ecstasy for the next couple of weeks to give his brain 'a rest', but later that day a friend messages him, inviting him to a new club the following evening. It sounds like it will be an amazing evening, and John starts to think it might be too good to miss.

John, an experienced ecstasy user, takes the drug to give him feelings that he would otherwise struggle to achieve or maintain. He carefully plans his use of ecstasy to give him the maximum benefit while minimising the negative effects. He also uses the sedative effects of cannabis to calm himself down and help him sleep.

His story is typical of many 'recreational' drug users, who often think carefully about the dose they want to use and frequently combine more than one drug to achieve the best effect. Mixing a stimulant and sedative drug is particularly common – ecstasy and cannabis or cocaine and alcohol are good examples. Whether John has as much control over his drug use as he thinks is unclear.

Jake's Story

Jake has worked in the customer service department of a large company since leaving school a year ago. He is a studious, precise and shy person who describes himself as 'always a bit nervous around people'. Jake likes his job and is good at it. He was recently promoted and now manages a team of 14 people. Since his promotion, Jake has felt much more pressure due to the increased responsibility of managing his team but also from his new boss to hit company performance targets. He has found the work increasingly challenging and returns home from work most days feeling stressed, worried that he is not up to the job and that he will end up being demoted or sacked.

Jake has never really been interested in drugs, with the exception of cannabis, which he has used on and off since he was 14 years old. He now buys small amounts from a friend and smokes it on his own in his flat a few times a week as a 'bit of a treat'. It helps him relax, particularly after stressful days at work.

Over the past 6 months, Jake has noticed that his cannabis use has gradually increased and that he is now smoking every evening. In fact, over the past few weeks, the first thing he does when he gets home from work is smoke a joint, followed by two more joints later in the evening before he goes to sleep. He now finds that without cannabis he struggles to sleep and feels 'edgy'. Jake is worried about the cannabis use and blames work and his overbearing boss.

A few weeks ago, during a particularly difficult day at work when 5 of his 14 staff called in sick, Jake had a panic attack. He felt emotionally overwhelmed, distressed and paralysed by fear. Hyperventilating, and with his heart beating so fast he thought he was having a heart attack, Jake left the office and went outside for some air. All he could think about was that his boss was expecting him to report on the company performance targets that afternoon, targets Jake knew had not been achieved.

Instead of going back to the office, he went home and rang a work colleague to explain that he was not feeling well. Once home, feeling very shaky and with his heart still racing, Jake rolled himself a large joint of cannabis, which he quickly smoked. Within a few minutes he felt himself calming down. He smoked a second then a third joint, by which time he was feeling much better. His anxiety had completely gone and was replaced by a powerful feeling of calm and well-being. Jake rolled a final joint before falling asleep.

The next day, even the prospect of going to work felt overwhelming to Jake, but he knew that his boss would be waiting for his presentation and would be angry if he did not show up. To calm himself, Jake smoked a 'small' joint of cannabis before leaving for work, just enough to reduce his anxiety. He rolled a second joint and put it in his wallet. Jake knew this was a risky thing to do but couldn't think of any other way to cope.

A few weeks later, I met Jake at the clinic. He was in a terrible state, having been fired from work and overwhelmed with anxiety. He asked if I could help him. Although Jake felt cannabis was the main problem, it soon became clear that his anxiety was the main issue to tackle.

Jake uses cannabis to control his anxiety. He has probably always been more anxious than others, and the sedating effects of cannabis, when used in moderation, have worked well for him over the years. But as his stress levels increased, so did his cannabis use. The recent panic attack made him fearful of losing control at work.

Unfortunately for Jake, the more frequently cannabis is smoked, the greater the risk of tolerance. Tolerance develops when the brain becomes used to a drug through repeated consumption. The brain adjusts to repeated drug use by making itself less sensitive to the drug. Therefore, a person needs to take more of the drug to achieve the same effect. Jake's tolerance to cannabis means that he has been smoking more, as well as more often. He is at risk of becoming dependent on cannabis unless he finds other ways to manage his anxiety. In the long run, psychological techniques – teaching him skills to control his anxiety – will be much more helpful than psychoactive drugs.

Some people use drugs to take away very difficult, distressing feelings that they struggle with every day. The despair of depression, traumatic memories or the emotional pain of a recent bereavement, for example, are feelings that can lead people to the psychologically soothing effects of psychoactive drugs. In the short term, psychoactive drugs can make difficult feelings less intense or disappear altogether, but of course the drugs won't address the underlying problems, only temporarily mask them.

Drugs to Numb Physical Problems

Psychoactive drugs change our psychological experiences, but they can change our physical experiences too. Several powerful psychoactive drugs also reduce pain. Opioids such as codeine or benzodiazepines such as diazepam are medications with powerful psychoactive effects. When prescribed and carefully monitored for pain management, these drugs can be extremely helpful, but serious harm – including dependence – can result from their misuse. We will discuss the potential harms from medications in more details in Chapter 8.

Drugs for Other Reasons

Drug use is an attempt to experience new feelings or take away unwanted ones. For some people, this extends beyond the direct feeling caused by the drug. Drugs can make people feel good in other ways, offering an escape from responsibility, a personal reward or satisfaction in breaking the rules.

Drugs for Social Gain: Peer Groups and Fitting In

Drugs can also make people feel good through social gain. In particular, for those who find it difficult to fit in with others, using drugs can give access to certain subcultures. Subcultures can offer a sense of belonging and identity that someone struggles to find elsewhere.

We've all heard the phrase 'falling in with a bad crowd'. Very often parents describe how their teenager was doing well until they met a new group of friends who the parents felt were a bad influence. They believed, often correctly, that the new friend or friends introduced their child to drugs and that this was the root of the problem.

Most of us like to fit in. We are social animals and like to feel part of a group or community. Belonging feels good.

Using drugs is sometimes seen as a way to increase credibility with peers. Acts of recklessness can increase status within a peer group and be seen as mature or brave. If drug-taking is praised or admired by others, this makes the user feel good about themselves. With this social gain, it is likely that drug use will continue. For some, the social gains from drug use can be more important than the drug use itself (Yali, 2019).

Hannah's Story

Hannah is 15 years old and in trouble. She has been sent to see me by her exasperated parents because she has just been suspended from school for truancy and smoking cannabis. Hannah is preparing for her GCSE examinations, which are in a few months' time – or at least she should be preparing. In truth, she has not even started her exam revision and seems to accept that she will fail everything.

As Hannah and I begin to talk, she tells me that she feels like a 'freak' at school because her interests and musical tastes are different from those of her classmates. Hannah believes she has never really fit in and has only recently found people like her.

These new friends come from outside her school and are older than Hannah. Most of them have already left school and are looking for work. They share Hannah's passion for electronic dance music and the culture surrounding it and spend time listening to and making music. Hannah will often leave school after lunch to spend time with them, something she finds exciting.

I ask Hannah about drugs, and she explains that she doesn't really like them but has smoked quite a lot of cannabis with her new friends 'because that's

what they do'. The cannabis makes her anxious and gives her a headache, but she never refuses, as 'that would be really uncool'. Hannah's classmates know about her drug use and now avoid her even more than usual.

When I ask what she thinks will happen next, Hannah becomes very distressed and starts crying. She explains that she feels trapped, disliked at school but out of her depth with her new friends. She is worried about the cannabis and has felt quite paranoid the last few times she smoked the drug, believing that the police somehow knew what she was doing. She doesn't feel able to refuse cannabis from her new friends, as she is desperate not to be rejected by yet another group of people. Hannah is also frightened because some of the new group use 'stronger' drugs, such as ketamine. Although she has not been offered these other drugs yet, she knows it is only a matter of time.

It becomes clear that Hannah is very unhappy both at school and at home. She is intensely lonely and very sensitive to rejection by others. Importantly, Hannah knows that her life is 'going wrong' but doesn't know what to do about it.

This was the first of many meetings I had with Hannah, meetings that also came to involve her parents, the school, a family therapist and a social worker. Hannah dropped down a school year and, at the time of writing, is still in treatment, not using drugs and making steady progress. As I got to know Hannah better, she continued to describe feeling out of place and different from her peers, and I began to think more about her difficulty with social interaction and making friends. Hannah and I discussed whether it would be helpful to arrange an assessment for autism, and she readily agreed. The assessment showed that Hannah had mild autism, and that this explained her powerful feelings of confusion and anxiety in social situations. The focus of our work soon shifted away from drugs to focus instead on how Hannah could better cope with social anxiety and use the new understanding of her autism to better manage daily life.

Some groups of people are particularly vulnerable to developing drug problems. Children with existing emotional difficulties or problems with learning or social interaction can, without appropriate help, find environments such as school extremely challenging. This can lead them to seek out peers who also feel disenfranchised and left on

the social margins. Conditions such as autism spectrum disorder and attention-deficit hyperactivity disorder (ADHD) are increasingly recognised, and children with these problems need proper assessment and support.

For those experiencing emotional distress, psychoactive drugs can seem particularly appealing. Intoxication can provide a brief refuge from difficult thoughts and feelings, and so it is perhaps no surprise that children who have experienced neglect or abuse are at greater risk of drug misuse. In Chapter 11 we will look at different underlying mental health problems which can increase the risk of psychoactive drug use.

KEY MESSAGES

- People use psychoactive drugs to change the way they feel.
- Psychoactive drug use can result in new feelings that would otherwise be hard to experience, or take away unwanted feelings.
- Sometimes psychoactive drugs are used for social gain, bringing a sense of belonging and identity.
- As we will see in Chapter 11, some people experience mental health problems which increase their risk of using drugs
- The United Kingdom has two drug laws, the Misuse of Drugs Act 1971 and the Psychoactive Substances Act 2016. These laws place all psychoactive drugs under control and rank some drugs according to their potential to cause harm.
- The UK drug laws make it an offence to produce, supply, import or export and, in some cases, possess a psychoactive drug.